Mississippi Perinatal Quality Collaborative
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Director
MSPQC BACKGROUND

- Launched November of 2014
- 3 Divisions
  - Maternal
  - Neonatal
  - Family & Community
- 2016 joined Alliance for Innovation on Maternal Health (AIM)
- 2018 CDC funding
Our Team

C. Collier MD, MPH
Director/OB Lead

Monica Stinson, MS
Program Manager

Jasmine Williams MPH, LPN
Project Manager

Constance Bourne, MPH
Data Analyst

Janice Scaggs, DNP, CNM
OB Lead Vaginal Birth

Kara Driver MD, MPH
Neonatal Lead

Kim Sheffield, NP
Neonatal Lead

Mobolaji Famuyide, MD
Neonatal Lead

Lakisha Crigler, MD, MBA
OB Lead Hypertension

Jim Martin, MD
OB Lead Hypertension

Stephanie Swiley, RNC-OB
Simulation Trainer
Partners
Racial Equity

• Evaluating all practices
• Data by race, geography, payer with focused goals to achieve equity
• 2021 Goal: Racial equity training for all birthing facilities in partnership with National Birth Equity Collaborative
• 3 Mississippi Hospitals/MSPQC partner with SACRED Birth Study to evaluate measures of Obstetric Racism

SACRED Birth During COVID19

The SACRED Birth Study is designed for, by, and with Black mothers and Black birthing people to share information about their patient experiences in hospital settings during labor, birth, and postpartum in six key areas:

Safety, Autonomy, Communication, Racism, Empathy, and Dignity.
Landscape

- 42 Birthing Facilities in Mississippi
- ~37,000 births per year
- 65% Medicaid
- 1 Level IV NICU Level/Academic Medical Center
- 10 III NICUs
- No Birthing Centers
- 429 ob/gyns in 36 of 82 counties
- ~10 MFMs
Maternal Outcomes
Past Initiatives

• Early Elective Deliveries
• Severe Maternal Hypertension 1.0
• Obstetric Hemorrhage Initiative (AIM)

• Neonatal Golden Hour

• Partner- Baby Friendly Hospital Initiative (CHAMPS/Boston University)
Current Initiatives

- Maternal
  - Hypertension & Heart
  - Initiative to Support Vaginal Birth (I-Support)

- Neonatal
  - Neonatal Abstinence Syndrome
  - Express Yourself- Human Milk in NICU
By November of 2021, for mothers with confirmed severe maternal hypertension:

- Increase proportion treated for severe HTN in <60 minutes to >80%
- Increase proportion receiving preeclampsia education at discharge to >80%
- Increase proportion with follow-up appointments within 10 days to >80%
- Increase proportion of cases with provider/nurse debriefs to >80%
- Reduce hypertension related mortality in Mississippi by 20% by 2021

All facilities conducting at least one annual drill on maternal cardiac arrest annually.
Hypertension & Heart Activities

- Documented hypertension management protocol (JCAHO)
- Provider and nurse education on severe maternal hypertension
- Debriefs
- Multidisciplinary case reviews
- Patient education materials
- Electronic Health Record integration of order sets
- Drills twice per year
- Toolkit development and materials dissemination
- Annual Kick Off
- Monthly Coaching Team Calls
- Quarterly Individual Calls
- AIM Database Entry & Tracking
- Advanced Life Support in Obstetrics Simulation Training (ALSO)
- Celebrations/Recognitions
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<thead>
<tr>
<th></th>
<th>2016</th>
<th>2018</th>
<th>2020</th>
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<tbody>
<tr>
<td>Debriefs</td>
<td>10%</td>
<td>20%</td>
<td>67%</td>
</tr>
<tr>
<td>Case Reviews</td>
<td>10%</td>
<td>25%</td>
<td>76%</td>
</tr>
<tr>
<td>Patient Support</td>
<td>15%</td>
<td>25%</td>
<td>67%</td>
</tr>
<tr>
<td>Written HTN Policy</td>
<td>7%</td>
<td>7%</td>
<td>46%</td>
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<tr>
<td>EHR Integration</td>
<td>7%</td>
<td>7%</td>
<td>56%</td>
</tr>
<tr>
<td>Drills (quarterly avg)</td>
<td>&lt;1</td>
<td>&lt;1</td>
<td>1.6</td>
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Changing Culture & Convention

WHY AREN’T SEVERE BLOOD PRESSURES TREATED?

- “We have just one doctor who still wants to start with Magnesium”
- “We wait for the epidural to be in place”
- “The main concern is bottoming the mother and baby out”
- “We only call the doctor about ‘emergencies’”
- “We tolerate higher pressures in postpartum period”
- “If the patient has chronic hypertension, we don’t usually treat”
- “Our OB champion is the most junior person in the group”
Cesarean Delivery in Mississippi

Cesarean Delivery Rate by State

Initiative to Support Vaginal Birth (I-Support) Pilot

- Pilot of 5 hospitals to test process & data
- Goal: By 6/2021 reduce of primary cesarean due to failure to progress and failed induction of labor by 10%
Initiative to Support Vaginal Birth (I-Support) Pilot

1. Phase 1: Education & Training
2. Phase 2: Data sharing & Case Review
3. Phase 3: Policy Development
Phase 1 - Education/Training

- AIM eModules
- Physiologic Birth Education
- Hands-on /Virtual Training in Labor Support
- ACOG/SMFM Safe Prevention of Primary Cesarean
- Use of bedside checklist/review tool
### Initiative to Support Vaginal Birth (I-Support)

#### Phase 2 - Data Sharing & Case Reviews
- Monthly sharing of unblinded or blinded NTSV with providers, aggregate with OB Unit
- Proportion of primary cesareans performed for failure to progress or failed induction of labor that do not meet ACOG/SMFM Criteria

<table>
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<th>Criteria to meet ACOG/SMFM Indication</th>
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<tr>
<td><strong>Dystocia/Failure to Progress</strong></td>
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<tr>
<td>• Cervix 6cm or greater at time of CS</td>
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<tr>
<td>• Membranes ruptured and NO cervical change x 4 hours with adequate contractions (or 6hrs w/ oxytocin)</td>
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<tr>
<td><strong>Failed Induction</strong></td>
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<tr>
<td>• Bishop score at or above 6cm before elective induction</td>
</tr>
<tr>
<td>• Oxytocin used for a minimum of 12 hrs after membrane rupture</td>
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- Monthly team case presentation
  - A case that met criteria
  - A case that did not meet criteria
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<tr>
<th>Details from Case Presentations Highlight Challenges</th>
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<tr>
<td>Lack of in-house OB coverage drives 5pm cesareans</td>
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<tr>
<td>Lack of in-house Anesthesiology coverage slows overnight inductions</td>
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<tr>
<td>Small practices and solo providers balancing long labors and work schedules</td>
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<tr>
<td>Variable use of induction strategies: foley balloons, combined balloons with medications, IUPCs</td>
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<tr>
<td>Variable maternal support: Doulas, solid food, ambulation, showers</td>
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Initiative to Support Vaginal Birth (I-Support)

Phase 3 - Policy Development

State Level
- State/Payer level incentives
- Staffing shortages

Hospital Level
- In-house coverage
- Standardized education
- Standardized data sharing
- Maternal support policies

Arkansas NTSV (Low-risk Cesarean Rate, 1997-2016)

SOURCE: CDC NCHS (2016 data are provisional)
Next Steps

- Monthly data reporting to MSPQC
- Enrolling 5 additional teams, keeping small cohorts
- Patient/Family input - Local Cesarean Awareness Network
- Statewide kick-off November 2021
If you want to go fast, go alone; if you want to go far, go together.
--Kenyan Proverb

Thank You

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